

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G596	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2023
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NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP COD 1426 S ALVORD LN EVANSVILLE, IN 47714
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 05/18/23</p> <p>Facility Number: 001110 Provider Number: 15G596 AIM Number: 100240090</p> <p>At this Emergency Preparedness survey, Rehabilitation Center Developmental Services was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. At the time of the survey, the census was 8.</p> <p>Quality Review completed on 05/23/23</p>	E 0000		
E 0039 Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Ailstock	Residential Coordinator	06/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>§491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p>			

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	<p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise</p>			

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	<p>that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not</p>			

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	<p>accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural</p>			

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	<p>or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that</p>			

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	<p>requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,</p>			

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	<p>facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2</p>			

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	<p>years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise</p>			

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	<p>the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or</p>	E 0039	<p>E039 Easterseals Group Homes had planned to participate in a community wide drill this past year; however they have not been restarted since the COVID pandemic has ended. Administration has reached out to the local Emergency Preparedness coalition and was informed that information regarding the next community drill will be communicated to Easterseals through email. A facility based drill will be planned and implemented within the next 30 days in order to meet the life safety regulation of participating in an annual functional exercise. Group Home administration (Residential Coordinators) will organize a drill</p>	06/09/2023

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K 0000 Bldg. 01	<p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Preparedness Plan on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, the facility was unable to provide emergency preparedness documentation for two exercises performed to test the emergency preparedness plan during the past 12 month period. Based on interview at the time of record review, the Home Manager said she has only been the Home Manager for a short time at this home and was not sure if two exercises had been performed during the past 12 month period, and furthermore could not find documentation of two exercises performed during the past 12 month period.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p>	K 0000	<p>and implement it in all of the Easterseals Group Homes. Appropriate documentation will be completed, as well as follow up discussions allowing for problem solving on what worked well and areas of improvement related to the completion of the facility based emergency drill. Systemically, to ensure annual compliance, group home administrators will implement a facility based drill one time per year and/or a table top exercise as well to ensure we are meeting life safety regulations of participating in at least two annual exercise drills per year (in-house and/or community based).</p>		

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K S100 Bldg. 01	<p>Survey Date: 05/18/23</p> <p>Facility Number: 001110 Provider Number: 15G596 AIM Number: 100240090</p> <p>At this Life Safety Code survey, Rehabilitation Center Developmental Services was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detectors in the corridors, sleeping rooms, and common living areas. The facility did not have heat detection in the attic, but the attic is provided with sprinkler coverage. The facility has a capacity of eight and had a census of eight at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Impractical with an E-Score of 6.4.</p> <p>Quality Review completed on 05/23/23</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information,</p>			
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	<p>along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on record review, observation, and interview; the facility failed to ensure 2 of 2 interior emergency lights were tested, maintained, and the records of the testing maintained. LSC 33.1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. LSC 7.9.3.1.1 testing of required emergency lighting systems shall be permitted to be conducted as follows:</p> <p>(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds.</p> <p>(2) The test interval shall be permitted to be extended beyond 30 days with approval of the authority having jurisdiction.</p> <p>(3) Functional testing shall be conducted annually for a minimum of 1 ½ hours if the emergency lighting is battery powered.</p> <p>(4) The emergency lighting equipment shall be fully operational for the duration of the test.</p> <p>(5) Written records of visual inspections and tests shall be kept by the owner for inspection for the authority having jurisdiction.</p> <p>This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observations on 05/18/23 between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Home Manager, the facility had two battery powered emergency light units. Based on record review between 11:30 a.m. and 1:30 p.m., there was no documentation available to show that the</p>	K S100	<p>E100</p> <p>Alvord had a new manager that was still being trained all of her monthly duties at the time of the survey. Since the Life Safety survey, the group home manager has resigned and the Group Home Coordinator has stepped into the manager role. The Group Home Coordinator has been trained on their yearly responsibilities to ensure that the battery powered emergency light units are tested for 90 minutes one time per year and for at least 30 seconds every month. As well, as documenting these checks on the Fire Extinguisher Checklist form #5165. The group home coordinator will train the incoming group home manager of this responsibility to ensure that this is checked as needed throughout the year, and ensure that it is completed per life safety regulations.</p> <p>Systemically, all group home management in all eight Easterseals Group Homes have been retrained as well on the completion of the Emergency Light Checklist and Fire Extinguisher Checklist on a monthly basis. The completion of these emergency forms is also part of the RCDS Monthly Manager's Checklist that each</p>	06/09/2023

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K S345 Bldg. 01	<p>battery powered emergency light units were tested for 90 minutes during the past 12 months. Based on interview at the time of record review, the Home Manager confirmed there was no 90 minute test available for the past 12 months.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to provide complete documentation for the inspection of 1 of 1 fire alarm system in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, there was documentation available for an</p>	K S345	<p>manager utilizes each month to ensure all paperwork is completed and turned into the appropriate person.</p> <p>K0345 Sonitrol is the company that we utilize to inspect and maintain our fire systems and smoke detectors. Since the documentation provided after inspection did not meet standards as it did not include an itemized list of the location of the group homes heat detectors and pull stations, did not mark whether the smoke detectors passed or failed, nor indicated the manufacturer's calibrated sensitivity test instrument utilized. The report does indicate that the smoke detectors were within the passing</p>	06/09/2023

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	<p>annual fire alarm system inspection dated 04/25/23. This report did include an itemized list of the inspection and location of the facility's four heat detectors and three pull stations. Based on interview at the time of record review, the Home Manager agreed the 04/25/23 fire alarm system inspection documentation did not include an itemized list of the location of the facility's heat detectors and pull stations.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for the sensitivity testing of all smoke detectors was complete. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal 		<p>range; however the pass/fail box was not marked. It is also indicated that the SENS-RDR was the test method, but it will be clarified through Sonitrol if this is the sensitivity test instrument utilized. Sonitrol has been contacted by the supervisor of our maintenance department to ensure all of these areas are completed correctly in the future. To ensure completion, the maintenance supervisor will begin checking the document after inspection is completed to ensure the sensitivity range is marked pass/fail, the location of all the heat detectors and pull stations are documented, and the manufacturer's calibrated sensitivity test instrument utilized is documented on the report. The maintenance supervisor oversees all eight group homes, so the monitoring of these documents will ensure correction in all eight Easterseals group homes.</p>	

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K S353 Bldg. 01	<p>at the control unit where its sensitivity is outside its listed sensitivity range.</p> <p>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, the smoke detector sensitivity test report dated 04/25/23 was not a complete report. The manufacturer's calibrated sensitivity test instrument was not included on the report, furthermore, there was no indication of pass or fail for each smoke detector tested. Based on interview at the time of record review, the Home Manager confirmed the lack of the manufacturer's calibrated sensitivity test instrument and a pass or fail for each smoke detector tested on the 04/25/23 sensitivity testing report.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard</p>			

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	<p>for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.</p> <p>NFPA 13D Systems</p> <p>Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:</p> <ol style="list-style-type: none"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 			

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	<p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <p>_____</p> <p>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 sprinkler system. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1</p>	K S353	K353 Alvord has been without consistent management over the last year. This has resulted in paperwork that should be completed, not being done properly or not being filed and maintained in the proper location. Currently, the group home coordinator at Alvord, who has been recently hired, is completing the responsibilities of the weekly sprinkler system gauge and valve inspection form. Another group	06/09/2023

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	<p>states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all clients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, there was no weekly dry sprinkler system gauge inspection documentation available between 02/20/23 and 04/28/23. Furthermore, there was no monthly control valve inspection for March of 2023. Based on interview at the time of record review, the Home Manager acknowledged there was no documentation available to show the facility has performed weekly sprinkler system gauge inspections between 02/20/23 and 04/28/23, and monthly sprinkler control valve inspections for March of 2023.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 1 bedroom corridor. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect clients.</p>		<p>home coordinator is assisting to ensure appropriate training and completion of the weekly dry valve sprinkler checks and monthly control valve checks.</p> <p>Each of the eight group homes completes a weekly sprinkler system and valve inspections checklist. This form was developed in order to ensure the water pressure gauges, air pressure gauges, and control valves are checked and documented as required.</p> <p>However, this form has not been a part of the monthly management paperwork checklist. Therefore, at this time, the manager's monthly paperwork checklist will be updated to include the weekly sprinkler system and valve inspections checklist. The current group home coordinator has checked the valves and completed the current inspection checklist. She will continue to do so until the new manager is trained and able to complete the weekly/monthly task. The manager and coordinator of each group home are responsible for ensuring the completion of the valve checks are completed as outlined. The manager completes the check, and the coordinator follows up to make sure it was completed and documented. In this instance, the current coordinator will complete the checklist and the assisting coordinator will follow up to ensure</p>	

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	<p>Findings include:</p> <p>Based on observations on 05/18/23 between 11:30 a.m. and 1:30 p.m. during a tour of the facility with the Home Manager, the bedroom corridor was equipped with three quick response sprinkler heads and two standard response sprinkler head. Based on interview at the time of observation, the Home Manager acknowledged the bedroom corridor was equipped with a mixture of quick response sprinkler heads and standard response sprinkler heads.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>3. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested during 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but</p>		<p>completion and documentation. All group home management have been trained on the updated monthly paperwork checklist, with the addition of the weekly sprinkler system and valve inspections form being added. This will ensure systemic correction, as all the group home management team use the checklist to ensure completion of necessary paperwork.</p>	

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K S712 Bldg. 01	<p>not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all clients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, there was no third quarter (July, August, and September) of 2022 quarterly sprinkler system inspection available for review. During an interview at the time of record review, the Home Manager confirmed there was no third quarter of 2022 sprinkler system inspection report available for review.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>NFPA 101 Fire Drills Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; 			

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	<p>d. Investigate all problems with evacuation drills, including accidents and take corrective action; and</p> <p>e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i)</p> <p>1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on 3 of 3 shifts during 4 of 4 quarters during the past 12 months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, there were only nine documented fire drills available during the past 12 month period. There were no fire drill reports available for the following shifts and quarters:</p> <p>a. First (day) shift of the second quarter (April, May, and June), and third quarter (July, August, and September) of 2022 as so far in 2023.</p> <p>b. Second (evening) shift of the fourth quarter (October, November, and December) of 2022.</p> <p>c. Third (night) shift of the first quarter (January, February, and March) of 2023</p> <p>Based on interview at the time of record review, the Home Manager said there were no other fire drill reports available to review.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p> <p>2. Based on record review and interview, the</p>	K S712	<p>K712</p> <p>Alvord has been in transition with management over the last year. The group home coordinator and group home manager positions have both been difficult to maintain at Alvord. The inconsistency with management has created inconsistency in completion of fire drills and other paperwork. The current group home coordinator has been trained and understands how to complete quarterly drills. She is working to ensure they are being completed per the RCDS fire drill schedule, which outlines set dates and times for the completion of all the quarterly drills. Additionally, the group home coordinator has been trained that the drills must be filled out in their entirety and no documentation is left off, such as the time. Another group home coordinator is currently working with the Alvord Group Home Coordinator to follow up and ensure consistency and accuracy in completion of fire drills and other paperwork. To prevent</p>	06/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G596	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2023
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1426 S ALVORD LN EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility failed to ensure documentation on 1 of 9 fire drill reports was complete during the past 12 months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drill reports on 05/18/23 between 11:30 a.m. and 1:30 p.m. with the Home Manager present, the fire drill report from conducted on 07/04/22 was not provided with a time of day the fire drill was conducted.</p> <p>Based on interview at the time of record review, the Home Manager agreed the fire drill in question was not provided with a time of day the fire drill was conducted.</p> <p>This finding was reviewed with the Home Manager during the exit conference.</p>		<p>future occurrence and make systemic change, all quarterly drills for all eight group homes will begin being scanned into the office coordinator after completion on their assigned date/time. The office coordinator will follow up with group home management if the drills are not received or if any documentation on the forms are not completed correctly. This will ensure consistent and accurate completion of drills in all eight of the RCDS group homes going forward.</p>		